COMPLIANCE TEAM CHECKLIST

Subcontractor's Name: ______________________________
Center Director's Name: ______________________________
Date of On-site Review: ______________________________

On-site Visit conducted by: ______________________________, *Compliance Specialist*

Subcontractor and staff involved in On-site Review: (*Please have each individual sign.*)

______________________ ______________________
______________________ ______________________

Compliance Specialist must review findings with Subcontractor before leaving the site. Compliance Specialist must also give copies of completed reports to be submitted to LCP Office.

Quality Assurance Documents Reviewed	Exit Review conducted, Copies of all documents given to Subcontractor (*Check appropriate items*)	Compliance Specialist Signature	Subcontractor's Signature
Part I: Standards of Care			
Part II: Clinic Policies & Procedures			
Part III: Client Chart Review Forms? *List chart numbers of all client charts reviewed* ____, (*Use additional forms if additional room is needed to report client chart numbers*) Corrections must be completed by: __/__/____			
Part IV: Reporting Procedures:			
Part V: Resources, Referrals, and Informational Materials?			

Director is to faxed to 225-273-5931 and - - to confirm that charts have been corrected.
Compliance Specialist to submit this report along with copies of all supporting documentation Within 2 days of On-site Visit.

Compliance Document Instructions & Category Definitions

Standards of Care

OSHA Regulations -- standards of health and safety required for the operation of facilities. Agency must have OSHA Regulations available for review.

CLIA Waiver -- documents that the Agency complies with general standards in the disposal of human waste. A CLIA Waiver is required for the operation of facilities. Agency must have a CLIA Waiver available for review.

Technical Training -- Technical monitoring insures that effective training is conducted to center staff to insure successful execution of the Life Choice Project.

Clinic Policies & Procedures

Board of Directors Minutes - Review Articles of incorporation to identify the number of annual board meetings to be conducted. Review Board Meeting Minutes to ensure Agency complies with established policy regarding number of Board Meetings.

Board Meeting Notice Posted -- Agency is required to have information on file or posted for public inspection announcing the date, time, and location of Board Meeting. The availability of an Agenda is optional.

Proof of Required Insurance -- State law requires that all businesses operate with appropriate insurances. Review files to ensure coverage is current and in the agency's name. Types: Workman's Compensation, Professional Liability, General Liability, and .....

Clinic Record-keeping Process -- Records should be maintained in a secure, locked location; they should be organized in purple, chart order folders and should be easily accessible to staff. Each individual file should include all required paperwork, including result of pregnancy test, consent forms, health assessment and history, plan of care, and progress notes. schedule of follow-up visits. Additionally, all entries should be signed and dated by clinic staff and clients as required.

Resources, Referrals, and Informational Materials

Community Collaboration -- Agency should show evidence that it coordinates its services with other community agencies to facilitate the participants' access to community services and to prevent duplication of efforts. Agency should be knowledgeable about community resources and maintain a Community Resource Directory and/or listing of appropriate service providers to assist and support LCP eligible participants.

Educational Materials, Promotional Materials, Resources and Brochures -- All educational and promotional resources must meet approval by the Life Choice Project Administrative Office. Copies of materials distributed to LCP clients should be reviewed to ensure appropriateness. NO Christian literature may be distributed during LCP program components.

Chart Information -- All elements must be complete and in client file once service is provided.

Signature Page (100) -- Form that documents services provided by having client signature verification. Staff also signs as appropriate.

Client consent forms (101, 101-H) -- Agency staff reviews service information with LCP participant. Client completes consent form 101 on first visit. Form 101-H is also signed and dated, but date of actual service is left blank until the actual home visit. It is required on any visit to the home, including Birth Outcome visit.

Survey -- Document that introduces what client may expect during visit. Also includes icebreaker questions to allow agency to know client better.

TANF Eligibility (102) -- Agency staff assists client in completing eligibility form, identifies income and employment status. TANF worksheet must also be completed by staff: is client income monthly, weekly, yearly, etc?

Proof of Income / Citizenship -- Agency staff follows guidelines for establishing proof of eligibility by obtaining proof of income. Ex: paycheck stub, student fee sheet, unemployment verification form, etc. Federal Aid also implies eligibility. Agency must also obtain proof of citizenship, i.e.,, social security card (or use citizenship verification form and USA Trace or similar site), driver's license or other official picture id, college fee sheet to show Louisiana residency, etc.

Intake Form (103) -- Agency staff provides one-on-one interview with LCP participant.
Complete intake form with client.

Pregnancy Verification -- Documentation of pregnancy verification from physician, nurse, or state licensed midwife needed.

Care Plan / Risk Assessment (203) -- Documentation to verify Initial Risk Assessment for identification of client health status to reflect problems and concerns for healthy pregnancy. Care plan developed to address needs.

Case Management (104) -- Documentation of client support and assistance to verify referral services.

Exit Interviews (105 & 105-M) -- At the completion of the service, clients must be provided the opportunity to assess the delivery of service. This information is needed to gauge client's satisfaction and the need to re-examine LCP services.

Negative Test Education (310-N) -- Staff provides one-on-one counseling with client. Documentation of emotional assessment and questionnaire with STD education to inform clients of risk.

Follow-up Form (106) -- Ongoing coordination and monitoring of client's health status. Documentation needed to verify services to LCP participant for each visit.

Return Visit Form (234) -- Indicates client's desired service and needs; also serves as verification of contact information. Used for all clinic visits after the first visit. May not be used for visits in client's home (use 101-H).

Care Plan / Education Plan (301) -- Agency staff conducts one-on-one interview with LCP client to identify client health status to reflect problems and concerns for healthy pregnancy and lifestyle concerns.

Ongoing Care Part 2 (302) -- Re-assessment services provided. Identification of client health status to reflect changes, problems, concerns for healthy pregnancy.

Home Visit Counseling (103-104-H) -- Ongoing care and monitoring of client's health status and physical needs. Home visit documents should be in a yellow folder placed inside of purple folder.

Prenatal Home Visit Assessment (402) -- One-on-one counseling in client's home. Documentation to verify prenatal home visit. Identification of client health status to reflect symptoms, problems, concerns. Referred to doctor for follow-up.

Birth Outcomes (501-203P) -- One-on-one counseling; may be in hospital, home, or clinic. Documentation needed to verify services to LCP participant of Birth Outcomes. Identification of client health status to reflect problems, concerns, etc.

Family Services -- Services provided must match educational modules as listed on B-1 Billing Form. Modules must be provided in chronological order. May be offered in a one-on-one or small group setting. Documentation needed to verify services to LCP participant.

LCP QUALITY ASSURANCE COMPLIANCE

Initial On-site Review Scheduled On-site Review Follow-up On-site Review

Compliance Month _____ LCP Sub#: _____ LCP Subcontractor _____

Chart Number_____ Compliance Specialist:_____

1st Visit – Date Reviewed _____

(√) if documentation is correct and present (X) if documentation is incorrect or missing

_____100 Signature Page
_____ 101 Consent Form
_____ LCP Survey
_____ 102 TANF Eligibility
_____ Proof of Income/Citizenship
_____ Copy of ID/SS#
_____ 103 Intake Form
_____ Pregnancy Verification
_____ 203 Care Plan - Risk Assessment
_____ 104 Case Management
_____ 105 Female Exit Interview
_____ 105-Male Exit Interview
_____ 101-H Home visit consent form
_____ 106 Follow-Up
_____ 301-N Negative Test Education

FINDINGS:

_____

_____

_____

2nd Visit – Date Reviewed _____

(√) if documentation is correct and present (X) if documentation is incorrect or missing

_____ 100 Signature Page
_____ 234 Return Visit (N/A on expanded 1st visit)
_____ 301 Care Plan / Education Plan
_____ 104 Case Management
_____ Pregnancy Verification Medical Visit
_____ 106 Follow-Up

FINDINGS:

_____

_____

_____

3rd Visit – Date Reviewed _____

(√) if documentation is correct and present (X) if documentation is incorrect or missing

____100 Signature Page
____234 Return Visit
____302 On-going Care Part 2
____104 Case Management
____Testimony (optional)
____106 Follow-Up

FINDINGS:

_____

_____

_____

Home Outreach Services Visit - Date Reviewed _____

(√) if documentation is correct and present (X) if documentation is incorrect or missing

____100 Signature Page
____101-H Consent Form - (Med.)
____103-104-H Counseling Notes
____402 Prenatal HV Risk
____502-H Consent Form
____104 Case Management
____105 Female Exit Interview
____105-Male Exit Interview
____106 Follow Up

FINDINGS:

_____

_____

_____

Birth Outcome Visit – Date Reviewed _____

(√) if documentation is correct and present (X) if documentation is incorrect or missing

_____ 100 Signature Page
_____ 101 H Consent Form - (Med.)
_____ 203-501 Birth Outcome
_____ 104 Case Management
_____ 105 Female Exit Interview
_____ 105-Male Exit Interview
_____ 106 Follow Up

FINDINGS:

_____

_____

_____

Family Services – Date Reviewed _____

Must be provided in chronological order

Module #1 –Date _____
Module #2 –Date _____
Module #3 –Date _____
Module #4 –Date _____
Module #5 –Date _____
Module #6 –Date _____
Module #7 –Date _____

FINDINGS:

_____

_____

_____

Month Reviewed _____

Life Choice Project
Quality Assurance Compliance Checklist

Subcontractor's Name _____ **LCP #** _____

Center Director's Name _____

Compliance Specialist _____ **Date of Visit** _____

Client Services Assessment Form

Total Number of New Clients Enrolled in Life Choice Project _____

Total Number of Randomly Selected Charts for Review _____

Total Number of Charts with completed Client Assessment Form _____

Client services are performed as outlined on assessment form ___ yes ___ no
Client service limits are adhered to ___ yes ___ no
Appropriate documentation available in each client chart ___ yes ___ no

Number of Charts with accurate client information _____

Number of Charts with inaccurate client information _____

Findings: _____

Request for Reimbursement form & Monthly Activity Data Form

Agency understands appropriate procedures for reporting client services activities as outlined on the Request for Reimbursement Form ___ yes ___ no

Agency adheres to reporting requirements as outlined in the Monthly Activity Data Form ___ yes ___ no

Findings: _____

Review the following categories each month. Mark each line that is compliant.

Standards of Care ***Compliance Findings***

☐ OSHA Regulations
☐ CLIA Waiver _____

Clinic Policies & Procedures **Compliance Findings**

☐ Board of Director's Minutes
☐ Board Meeting Notice Posted
☐ Proof of Required Insurances _____
☐ Medical Staff Licenses and Standing Orders
☐ Center is working within proposed budget _____
☐ Clinic Record-keeping Process
☐ Records are organized and easily accessible

- ☐ Records are confidential and secure
- ☐ Records are available to client upon request with signed release
- ☐ Eligible client files are maintained in chart order and are in purple folders
- ☐ Client files contain required client id, personal data, and contact information
- ☐ Client files contain complete forms and appropriate documentation

Resources, Referrals, and Informational Materials ***Compliance Findings***

☐ Center coordinates and collaborates with other community agencies _____

☐ Center maintains and provides Community Referral Information

☐ Educational and Promotional Materials are used and are LCP approved _____

- ☐ Family services materials
- ☐ Brochures _____
- ☐ Other instructional resources
- ☐ **No** Christian literature is provided to Life Choice Project participants _____

Charts Reviewed (list each chart number below, include visit reviewed)

EX: 1134256 - HV	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

See individual client chart review forms for results and findings.

Compliance Visit Summary

- ☐ Exit Review conducted
- ☐ Copies of all documents given to Subcontractor
- ☐ Corrections needed -- Must be completed by ___/___/___

Corrections must be faxed to 225-273-5931 and to compliance specialist to confirm changes.

Notes _____

_____

_____

_____ _____

Subcontractor Signature **Compliance Specialist Signature**

Life Choice Project/Care Pregnancy Clinic Consent Form

Center No. _____ Chart No._____

Client's Name_____ **Date**_____
(Please Print)

Current Address_____
(Please Print)

City/State_____ **Zip Code**_____

Age_____ **Birth Date**_____/_____/_____ **Social Security #**_____-_____-_____

Phone Number (_____**)**_____ Home Work Cell Pager **Email** _____

Have you been here before? YES or NO If yes, has your name changed? YES or NO

From_____ To_____

Service desired (*CIRCLE ONE*) **Pregnancy Test** **Retest** **Medical** **Support** **Other**

****

I hereby request the Life Choice Project/Care Pregnancy Clinic to supply me with all complimentary pregnancy services including pregnancy testing.
There are two separate components to our services.

If a pregnancy test is done and appears to be positive, I should go to a medical doctor as soon as possible for a complete physical examination to confirm the results. I understand that the sooner I see a doctor and have a complete medical evaluation, the safer my baby and I will be.

I further understand that the results of the urine pregnancy test are not always correct. The earlier the test is done, the greater the chance of error, so the test results should always be confirmed by a physician, regardless of the test results.

Because this pregnancy test is self-administered and is given to me without charge for my own use, I hereby release the Life Choice Project/Care Pregnancy Clinic and its staff and employees from any and all liability arising out of or connected with this pregnancy test, particularly with regard to any errors in diagnosis based on this test.

The staff of the Life Choice Project/Care Pregnancy Clinic are volunteers who have received training in crisis pregnancy counseling. These volunteers, for the most part, do not have degrees in counseling, nor are they licensed by the state. The counseling provided is not intended as a substitute for professional counseling.' We offer information, emotional and spiritual support, and practical help. To ensure quality control, the LCP may monitor your case for quality assurance.

All information is kept confidential except if child abuse reporting laws apply or if we believe or hear that you are in danger of hurting yourself or others. Due to concern for your safety and/or Louisiana State Law, Care pregnancy Clinic is required to report knowledge of a client who is suicidal, homicidal, abusing a minor or a minor is being abused. If Care Pregnancy Clinic is aware that a crime has been committed (i.e. Carnal Knowledge of a Juvenile – Misdemeanor or Felony grade), the staff and volunteer peer counselors are mandated by LA State Law to report such instances to the appropriate law enforcement agency for further investigation.

The Life Choice Project/Care Pregnancy Clinic's services are intended for all persons who genuinely seek our caring help. Any attempt to obtain these services or resources under false pretenses is prohibited. To protect your privacy and the privacy of our peer counselors, any use of electronic recording devices during your peer counseling session is prohibited.

In accordance with HIPAA regulations, all client files are confidential, and no information will be released by electronic or other route to a third party, without the express written consent of the client. No confidential information will be released over the phone or by fax to anyone, not even the client. Separate client authorization must be obtained for non-routine disclosures and most non-health care purposes, except as required by law. In general, disclosures of information will be limited to the minimum necessary for the purpose of the disclosure. Information gathered therein shall only be released to the client in person, provided that written consent witnessed by CPC staff, and photo identification, has been obtained. Clients will have the right to request restrictions on the uses and disclosures of their information.

I hereby authorize the Pregnancy Center to obtain information from me in order to create a client record.

Client's signature_____ Date_____

**********DO NOT WRITE BELOW THIS LINE—FOR OFFICE USE ONLY**********

CPC Staff or Volunteer Signature_____ Date_____

Arrival time_____ am pm Client is a WALK-IN or APPT. Client is NEW or RETURN

Client total stated monthly Income $_____

Worksheet on Family Income
Eligibility for TANF-Funded Services
(Back of Eligibility Form TANF-EZ #T101-06)

Income for Families at 200% of Poverty 2016 Federal Poverty Guidelines				
Family Size	Annual	Monthly	Weekly	Hourly
1	$23,760	$1,980	$457	$11.43
2	$32,040	$2,670	$617	$15.42
3	$40,320	$3,360	$776	$19.40
4	$48,600	$4,050	$935	$23.38
5	$56,880	$4,740	$1,095	$27.37
6	$65,160	$5,430	$1,254	$31.35
7	$73,460	$6,122	$1,414	$35.34
8	$81,780	$6,815	$1,574	$39.35

If Family Size is over 8, add $8,320 for each additional family member.

Financial Eligibility (to be completed by program staff person):

1. Family size___ (number of adults and minor children who are related to each other. Non-custodial parents need to live with their minor child and should use a family size of one.)

2. The total family earned income is $_____ (circle one: week, month, or year)
(This is money earned from employment, and before taxes.)

3. The total family un-earned income (ex: child support) is $_____ (Circle one: week, month, or year).

4. Convert to a monthly amount (divide yearly amount by 12) and list the family's total monthly income: $_____.

5. Is this amount less than 200% of the federal poverty level on the above chart? ▯ YES ▯ NO
If YES, the family is eligible for TANF-funded services. If NO, the family is not eligible for TANF funded services based on earned income.

Comments / Notes: _____

Name of program staff person (Please print): _____

Signature: _____

Date: _____

Louisiana Life Choice Project Evaluation Survey

Could you help us with our survey? All our services are complimentary regardless of your income or employment status. Thanks for your time.

I am working Yes No I have insurance Yes No

I have Medicaid Yes No I have LaCHIP Yes No

I receive FITAP Yes No I receive KCSP Yes No

I receive CCAP Yes No I receive food stamps Yes No

I receive free/reduced-cost lunches Yes No I receive SSI Yes No

I receive other government assistance Yes No Which_____

I receive an income Yes No

I will contact CPC in the event of any income changes.

Client signature_____ Date_____

4C

Form 102

To be completed by program staff to determine eligibility for TANF funded services. (Complete this form AND any attachments.)	DEPARTMENT of SOCIAL SERVICES	**TANF-EZ Eligibility Form for TANF-Funded Services**	

SECTION I: Identifying information

Name:	Address:	City:	Zip:
Phone Number:	SSN:	Date of Birth:	

SECTION II: Eligibility information Check the following if:

STEP 1: ☐ The family indicates they receive FITAP, KCSP payments, free/reduced school lunch, food stamps, Medicaid or LaChip. Letter of eligibility or other official documentation should accompany this form to verify receipt of one or more of these services.

- ❖ If Step 1 is checked, skip Step 2 and complete Steps 3 and 4.
- ❖ If Step 1 is not checked, complete Step 2.

STEP 2: ☐ The family income is less than 200% of the federal poverty level (see Page 2 for income chart and complete Financial Eligibility Section on that page).

- ❖ If either Step 1 **OR** Step 2 is checked, the family is *financially* eligible for TANF-funded services – if the family is financially eligible, proceed to Steps 3 and 4 to complete eligibility determination.
- ❖ If neither Step 1 nor Step 2 is checked, **STOP** - the family is **NOT** financially eligible for TANF-funded services – if the family is NOT financially eligible, go to Section IV.

STEP 3: ☐ The family applying for services includes a parent or relative caring for one or more minor children. A minor child is an individual who: 1. Has not attained 18 years of age; or 2. Has not attained 19 years of age and is a full-time student in a secondary school or in the equivalent level of vocational or technical training (individual should provide documentation of their parental status); or a pregnant woman.

STEP 4: ☐ The TANF-funded services are for the benefit of a family member who is:

- A citizen of the United States; or
- A non-citizen who meets the TANF-eligible citizen criteria (For determination, complete the attached sheet entitled "TANF-Funded Services for Non-Citizen Eligibility").

- ❖ If both Step 3 **AND** Step 4 are checked, the family is eligible for TANF-funded services – if the family is eligible, go to Section III.
- ❖ If either Step 3 or Step 4 is **not** checked, the family is **not** eligible for TANF-funded services - if the family is not eligible, go to Section IV.

SECTION III: TANF Service Goal

The services being provided are designed to: [please check one of the following]

- ☐ 1. Provide services to needy families so that the child or children may be cared for in their own home or the home of relatives.
- ☐ 2. Promote job preparation, work or marriage.
- ☐ 3. Prevent or reduce the incidence of out-of-wedlock pregnancies.
- ☐ 4. Encourage the formation and maintenance of two-parent families.

SECTION IV: Eligibility Criteria

I certify that the information provide on this form is true and correct to the best of my knowledge. If the information changes, I will notify a program staff person of the new information.

_____ _____

Signature of Responsible Family Member — Date signed

OFFICE USE ONLY:

Based on the information provided, the family is ☐ **eligible** OR ☐ **not eligible** for TANF-funded services for the period:

_____ through _____

Name of program staff person (Please print): _____

Signature: _____ Date: _____

DEPARTMENT of SOCIAL SERVICES

TANF-Funded Services for Non-Citizen Eligibility

(attach to DSS Form TANF-EZ)

Applicability and Scope: This form is to be used to determine eligibility for TANF-funded services for families who are non-citizens. In situations where some family members are citizens, some family members are non-citizens and the services are for the benefit of the family, the family would generally be eligible on this factor. If there is any discernable benefit to a family member who is a citizen, then the status of other members of the family does not need to be determined because the family is eligible due to the status of the citizen. The potential eligibility for non-citizens would be relevant when all of the family members are non-citizens, or when the services being provided are solely for the benefit of a family member who is not a citizen.

If some family members are eligible non-citizens, and some family members are ineligible non-citizens, then the family would generally be eligible, unless the service was provided solely for a member who is ineligible.

Note: Non-citizen eligibility can be very complex. This form is intended to provide guidance that will cover many circumstances. If eligibility cannot be determined for an individual or family, consult with the applicable Department of Children and Families Program Office.

Eligibility for Services (section references are from the immigration and Nationalities Act):

Step 1 – Are the relevant member(s) of the family lawful permanent residents who are:

- ☐ Granted asylum under section 208
- ☐ Individuals with deportation withheld by INS under section 243(h) or 241 (b)(3)
- ☐ Refugees under section 207
- ☐ Cuban/Haitian Entrants
- ☐ Amerasians

If any of the above, the family is eligible for TANF-funded services. If not, go to Step 2.

Step 2 – Are the relevant member(s) lawful permanent residents, who are not listed in Step One AND who were in the U.S. prior to August 22, 1996? ☐ YES ☐ NO

If YES, the family is eligible for TANF-funded services. If no, go to STEP 3.

Step 3 – Are the relevant member(s) lawful permanent residents who are not listed in Step One AND who did not enter the U.S. until after August 22, 1996? ☐ YES ☐ NO

If YES, the relevant member(s) are not eligible until 5 years after the date of entry (Family members who are not in a status described in one of the steps above are not likely to be eligible for TANF-funded services).

Eligibility Determination: The family is eligible based on the non-citizen status of relevant member(s): ☐ YES ☐ NO

Comments/Notes: _____

_____

Name of program staff person (Please print):	Signature: _____ Date: _____

Last Revised: 12/18/2014

Like Us on Facebook Y or N

Louisiana Life Choice Project Client Intake

Form 103

Date: _____ **Chart #:** _____ **Explained Division of Service:** Y N **Center #** _____

Name: _____ **Birth date:** ____/____/____ **Age:** _____

Street: _____ **City/State/Zip:** _____ **Parish:** _____

Email: _____ **Phone #:** _____ Home Cell Work **May we text appt reminder** Y N

Race: Asian Black Hispanic White Other_____ SS#_____-_____-_____

Marital status: Divorced Engaged Married Separated Single Widow Unknown

Lives alone? Yes or No **Lives with:** _____ **Homemaker?** Yes or No

Employed? No Yes ___PT ___FT **Student?** Y N **Highest Level ED** HS Col Trade School GED Other_____

Referral source: Return Family Friend Medicaid Office Health Unit Counselor

Doctor Church Phone Book Internet Ad School Sign Other_____

First day of last menstrual cycle: ___/___/___

 # Days that cycle lasted:_____

Was that last cycle?
Normal Heavy Light Spotting Clots

Usual # days between cycles: _____

Pregnancy History:
Previous pregnancy: _____ How many? _____
Delivery: _____ How many? _____
Miscarriage: _____ How many? _____
Abortion: _____ How many? _____
Weeks at abortion/termination: _____
Reason for abortion: _____
Have you ever been coerced to have an abortion? Y N

Symptoms: Yes No **# days evident** ___ **(Circle)** Nausea Appetite change Dizziness Tire easily Breasts tender

Contraception: Condom Pill None Other _____ **Previous STD?** Y N **which one?** _____

Medication - last 3 days? _____ **Smoke?** Y N **Alcohol?** Y N **Drugs?** Y N

Are you under psychological care? Y N **If so, where?** _____**Depression or suicidal thoughts?** Y N

Any previous suicide attempts? Y N **How many?** _____ **What method?** _____

Do you know what Domestic Violence is? Y N **Are you experiencing it?** Y N

What are your plans if you test positive? Abort Keep Place for adoption Undecided

Tensions: (draw out feelings to get tension) Expose real conflict * Relieve the pressure * Instill Hope * Redirect Alternative Outcome
Feelings about this potential pregnancy ___Good ___Not Good (Circle one tension below)

My Life vs. Baby's Life Ex "I just can't deal with a baby right now. I have plans for my life, and a baby doesn't fit that."
No Life vs. Quality of Life Ex "It would just be wrong to bring a child into my horrible circumstances.."
Remorse or Humiliation Ex "I feel so stupid for getting pregnant. My parents would kill me if they knew."

Adoption Presentation Given: Yes No **Feelings on Adoption:** _____

Feelings on abortion: _____

The test is 97% accurate. I hereby give my consent to be tested. I understand that all this information is confidential.

CAUTION HEALTH HAZARD

_____ **Client Initial** **If you have an untreated STD you must receive treatment before an Abortion.**

Client Signature: _____ **Date:** _____

Test result: Negative Positive **Due Date (EDD):** _____ **#weeks:** _____

Time In: _____ **Time Out:** _____ **Total Length of Session:** _____

4/0

Life Choice Project

Form 203

First Visit Risk Assessment Date of Visit: _____

sk Assessment:

___ P___ AB___ SAB___ LMP___ EDD_____ Weeks Now ___

s: Y N Quit___ ppd___ Alcohol Y N Last intake____

ecreational drugs: Y N Last intake___ Vitamins/herbs: Yes No _____

rescription/OTC meds: Yes No_____

ow is the patient feeling today? Happy Nervous Calm Sad Crying Confused

omplaints/Symptoms & Duration _____

lovement felt: Y N Unknown # Weeks_____ Blood type_____

ast medical history: Y N _____

revious hospitalization/surgery: Y N _____

amily Medical History _____

reated for/told she had STD's? Y N _____

nsurance? Y N Medicaid? Y N Apply

roblems with previous pregnancy? Yes No N/A _____

o you have an Obstetrician? Yes No Dr. _____

ver had a pelvic exam? Y N Which hospital? _____ Unsure

ho has been told about this pregnancy?_____

N d of eligibility for WIC, LaCHIP, FITAP, CCAP, KCSP, ETC. Yes No

SAFE HAVEN: Y N Brochure Explained: Y N Adoption Presentation: Y N

Client Understands Materials: Yes No NOTE: WE ARE NOT A SAFE HAVEN SITE.

Abortion Coercion Material Explained: Y N Client Understands Material: Y N

Video Seen: _____ Curriculum Taught: _____

Client Understands Material: Y N Family Present: Y N Relationship: _____

Prenatal Care Plan 1

Services Provided: Letter of Verification___ Nutritional___ Counseling ___

Instruction on prenatal vitamins Yes No Abstinence/STD Education Yes No

Discussed other topics_____

Printed material provided:

____Prenatal health instructions ____Nutrition _____

____Medicaid documents ____Childbirth class _____

____Record of health history ____Other _____

Referral to OB/GYN: ___Routine ___Urgent

Disposition of Case (see referral sheet for community referrals):

Abstinence-Fidelity Discussed Y N ER precautions Y N

Advised to see MD for blood pregnancy test for Signs and Symptoms of Pregnancy Y N

Identify Problems (including health & nutrition) _____

*Primary objectives of referrals & outcome goals*_____

*Client's responsibilities*_____

Life Choice/ Follow-Up Risk Assessment Expanded 2nd Visit

FoFm301

COPY

Date of Visit: _____

EDD from last visit: _____ # weeks now by LMP _____

Smokes: Y N Quit_____ ppd____ Alcohol: Yes No Last intake_____

Recreational drugs: Yes No Last intake_____

Vitamins/herbs: Yes No Prescription/OTC meds: Yes No _____

How is the patient feeling today? Happy Nervous Calm Sad Crying Confused

Complaints/symptoms & duration_____

Movement felt: Y N Unsure # Weeks_____ Applied for Medicaid? Y N

Received card? Y N Yes-temporary card Other insurance? Y N
Have you seen an OB/GYN? Y N Appointment pending Y N
Other services (eg. WIC)? Y N
Received any other medical care? Y N _____

Comments:_____

Support Visit Educational Session:
Video Seen: _____
Curriculum Taught: _____
Family Present: yes no Relationship: _____

Care Plan:

Services provided:
Nutritional counseling: Y N
Instruction on prenatal vitamins: Y N
Abstinence/STD education: Y N
Discuss other topic(s)_____

Printed material provided on: Prenatal health instructions _____
Nutrition: _____ Medicaid documents: _____

Record of health history: _____ CPC childbirth class: _____
Other: _____

Gift item provided: Y N _____
Referral to OB/GYN: Routine Urgent _____

Disposition of Case (see referral form for community referrals):
Emergency room _____ Home Visit _____ CPC support services _____ Letter of verification:_____ Other: _____

Educational Care Plan/*Level of education:*
Continue High School ___ GED/Adult Ed. ___
Advanced Ed. ___ Vocational/Technical Ed. ___
Other Ed./Job Training ___ No future educational plans at this time ___

Other individuals who participated in the educational care plan:
_____

Hindrances in accomplishing goals:
_____

Client Services
Schedule Child Birth Class Yes No Post Partum Yes No
Home Visit Yes No Counseling Yes No

*Primary objectives & goals for education:*_____

Resources and/or Referral (see referral sheet for community referrals): ___ *Printed materials*

What steps have been taken by client to accomplish these goals?
_____

*Strengths to help accomplish goals:*_____

Life Choice/ On-going Care & Monitoring # 2 Form 302

Date of Visit: _____

Risk assessment since last visit:

EDD from last visit: _____ **# weeks now by LMP** _____

Pregnancy Confirmation Provided Y N

Smokes: Yes No Quit___ ppd___ **Alcohol:** Y N Last intake_____

Recreational drugs: Yes No **Last intake**____ **Vitamins/herbs:** Yes No

Prescription/OTC meds: Yes No _____

How is the patient feeling today? Happy Nervous Calm Sad Crying Confused

Complaints/symptoms & duration _____

Movement felt: **Yes No Not sure** # Weeks___

Applied for Medicaid? Y N Apply **Received card?** Y N Yes-temporary card

Other insurance? Y N **Other services (e.g. WIC)?** Y N _____

Have you seen an OB/GYN? Y N Appointment pending _____

Have you received any other medical care? Y N _____

Needs/Concerns:_____

_____

Recommendations:_____

Counseling

Family Needs Family type/size

_____

Mental Health: Coping skills and Socialization skills

_____

Schedule Child Birth Class: Yes No _____

Printed materials provided: Yes No _____

Referral: Academic-Occupational Training Y N (See Form 104-P)

Family Present: Y N Relationship: _____

Health Education

Gestational Diabetes:	Yes No	Preeclampsia:	Yes No
Nutrition (diet):	Yes No	Exercise level:	Yes No
Smoking:	Yes No	Drinking alcohol:	Yes No
Drugs:	Yes No	STDs:	Yes No

Life Style Concerns:

_____

_____

Resources and/or Referral (see referral sheet for community referrals):

Support Visit 2 Educational Session:

Video Seen: _____

Curriculum Taught:

COPY

Form 301-N

Life Choice Project –Negative Test Counseling

Date: _____

How do you feel about your negative Test? ___Relieved ___Sad ___Angry

What is the reason you feel that way? (Client's remarks)_____

_____

Solution _____

_____

Risk Assessment:

Smokes: **Yes No Quit**____ ppd____ Alcohol: **Yes No Last intake** _____

Vitamins/herbs: **Y N** _____ Prescription/OTC meds: **Y N** _____

How is the patient feeling today? Happy Nervous Calm Sad Crying Confused

Treated for/told she had STD's? **Yes N** _____

Insurance? **Yes No** Medicaid? **Yes No Applying**

Do you have a Physician? **Y N** Dr. _____ Ever had a pelvic exam? **Y N**

Complaints, Symptoms & Duration _____

Movement felt: **Y N U** #Weeks _____ Blood type _____

Client's Responsibilities: _____

Client understands the following:

____Client advised to see MD for blood pregnancy test due to the presence of pregnancy signs and symptoms.

___Client advised of ER precautions.

STD Abstinence Education:

Abstinence/ Fidelity Discussed: Yes / No

CAUTION: IF YOU HAVE AN STD YOU MUST RECEIVE TREATMENT BEFORE AN ABORTION THIS CAN BE A HAZARD TO YOUR HEALTH

What is Pelvic Inflammatory Infection?

Common STD's

Viral – Incurable

____Human Papilloma virus (HPV) ____Genital Herpes

____Hepatitis B ____HIV/AIDS

BACTERIAL – Curable (Under right conditions)

___Syphilis ___Gonorrhea

___Chlamydia (also viral characteristics ___Pelvic inflammatory Disease PID

INSECTS – Parasites – Curable

___Pubic Lice ___Scabies

Other Education Completed:

Safe Haven Brochure Explained: Y N NOTE: We are not a Safe Haven Site.

Client Understands Brochure: Y N

Abortion Coercion Materials Explained: Y N Client Understands Materials: Y N

Video Seen: _____ Curriculum Taught: _____

Client Understands Materials: Y N

Family Present: Y N **Relationship:** _____

Please see back of 8 Relationship Questions for a guide to discuss abstinence.

41

Life Choice Project – Home Health/Hospital Visit Consent Form

I hereby give permission for Life Choice Project/_____ to conduct a complimentary Home Health visit for the purpose of providing educational, preventative, and support services during your pregnancy.

The staff of the Life Choice Project/_____ does not disclose client confidences and information to any third party except under the following circumstances in accordance with state law:

a. **The client expresses intent to harm him/herself or someone else.**
b. **There is reasonable suspicion of abuse/neglect against a minor child, elderly person (65 or older), or a dependent adult.**
c. **The client signs a Release of Information form indicating consent.**
d. **A court order is received directing the disclosure of information.**
e. **Any material shared by a minor client may be shared with the client's parent/guardian.**
f. **Verbal authorization will not be sufficient except in emergency situations.**
g. **In the case of family counseling, no information can be disclosed outside the treatment milieu without written authorization from all individuals involved, minors excluded.**

The staff of the Life Choice Project/_____ work from a family systems perspective and the belief that the family is the basic building block for society.

The staff of the Life Choice Project/_____ are not always registered health care providers. The counseling provided is not intended as a substitute for professional counseling. We offer education, emotional support, and practical help.

Client's Signature _____ Today's Date : _____ Date Actual Service: _____

Professional's signature _____ Today's Date : _____ Date Actual Service: _____

Parental Authorization

I, _____, give permission for _____ to conduct a home health visit with my _____, (name of minor).

LCP – Birth Outcomes

Form 501

Date and time of delivery: _____ Type of delivery: Vaginal or C-Section
Delivery location: _____ Gestational age: _____weeks Gender: _____
Birth weight: ____ *Breastfed*: Y N *Bottle fed:* Y N Formula Brand: _____ Baby's Name _____

Length of stay in hospital (check one)

Mother:	Baby:
_____Routine (1 or 2 days)	_____Routine (1 or 2 days)
_____Less than 1 week	_____Less than 1 week
_____One week to one month	_____One week to one month
_____Over 1 month	_____Over 1 month

Any Complications:

_____
_____
_____
_____
_____
_____

Level of education: Form 203-P

Continue High School ___ GED/Adult Ed. ___ Other Ed./Job Training ___
Advanced Ed. ___ Vocational/Technical Ed. ___ No future educational plans at this time

Educational Care Plan

Primary objectives & goals for education: _____
Resources and/or Referral (see referral sheet for community referrals): ___ ***Printed materials***

What steps have been taken by client to accomplish these goals? _____
Strengths to help accomplish goals: _____
Hindrances in accomplishing goals: _____
Other individuals who participated in the educational care plan: _____

Family Present: Y N Relationship: _____

Life Choice Project

Form 100
of purple folder.

Client Signature Form Checklist

Client Name _____
Chart # _____

Check Documentation & Signatures

1st Visit from Inside to Outside:
- ☐ 101 Consent Form
- ☐ 101-H Home visit consent form
- ☐ 102 TANF Eligibility
- ☐ 103 Intake Form
- ☐ 203 Care Plan - Risk Assessment
- ☐ Client advised to see an MD for pregnancy test
- ☐ Client advised of ER precautions
- ☐ Pregnancy Confirmation
- ☐ 104 Case Management (Medical/Edu.)
- ☐ 105 Yellow Exit Interview
- ☐ 105-M Blue Exit Interview
- ☐ 234 Return Visit
- ☐ 301 On-going Mon.1 *positive test only*
- ☐ 301 Support Visit Ed. Session
- ☐ 106 Follow Up Form

Services Provided:
Information listed below has been verbalized and thoroughly explained to my understanding.
- ☐ ER Precaution
- ☐ Safe Haven
- ☐ STD Abstinence Education/ Fidelity Discussed
- ☐ Academic Education
- ☐ Abortion Coercion

Negative Test ONLY:
- ☐ 101 Consent Form
- ☐ 101-H Home visit consent form
- ☐ 102 TANF Eligibility
- ☐ 103 Intake Form
- ☐ 234 Return Visit
- ☐ 301 N
- ☐ STD Abstinence Education/ Fidelity Discussed
- ☐ Client advised to see an MD for blood pregnancy test
- ☐ Client advised of ER precautions
- ☐ Academic Education
- ☐ Abortion Coercion

Client Signature _____ Date _____
Father Signature _____ Date_____

_____
Staff Date

2nd Vist from Inside to Outside:
- ☐ 104 Case Management
- ☐ 234 Return Visit (only for return negative test)
- ☐ 106 Follow Up Form

Client Signature _____ Date _____
Father Signature _____ Date_____

_____
Staff Date

Staple on the left i

3rd Visit from Inside to Outside:
- ☐ 104 Referral – Academic
- ☐ 234 Return Visit
- ☐ 302 On-going Care Part 2
- ☐ Pregnancy Verification Medical Visit
- ☐ 106 Follow Up Form

Client Signature _____ Date _____

Father Signature _____ Date_____

_____
Staff Date

Home Visit from Inside to Outside:
- ☐ 101-H Consent Form - (Med.)
- ☐ 103-104-H Counseling Notes - Food Consent
- ☐ 502-H Consent Form
- ☐ 402 Prenatal HV Risk
- ☐ 105-HPV Exit Interview - ☐ Map Quest

Client Signature _____ Date _____

Father Signature _____ Date_____

_____
Staff Date

Family Services:
- ☐ Module #1 – Client Initial _____ Date____
  Family member _____ Date____
- ☐ Module #2 – Client Initial _____ Date____
  Family member _____ Date____
- ☐ Module #3 – Client Initial _____ Date____
  Family member _____ Date____
- ☐ Module #4 – Client Initial _____ Date____
  Family member _____ Date____
- ☐ Module #5 – Client Initial _____ Date____
  Family member _____ Date____
- ☐ Module #6 – Client Initial _____ Date____
  Family member _____ Date____
- ☐ Module #7 – Client Initial _____ Date____
  Family member _____ Date____

Birth Outcomes Visit Inside to Outside:
- ☐ 101 H Consent Form - (Med.)
- ☐ 104 Case Management
- ☐ 105 HPV Exit Interview
- ☐ 203-501-P Food Consent Forms

Client Signature _____ Date _____

Father Signature _____ Date_____

_____
Staff Date

Life Choice Project

Life Choice Project: Case Management Form 104

Provider: _____ **Provider #**_____ **Client #**_____ **Date of Visit**_____

Check off any services needed:

Referrals
- ☐ Physician/Clinic Referral Name_____
- ☐ Emergency Rooms'
- ☐ _____
- ☐ WIC ☐ Medicaid
- ☐ Counseling
- ☐ Housing Referral
- ☐ Other (specify):_____
- ☐ Family Services Module # ____ - _____

Support Services
- ☐ Prenatal Care Education _____
- ☐ Maternity
- ☐ Baby Clothing
- ☐ Video
- ☐ Baby Care
- ☐ Other_____
- ☐ Other_____

Education & Occupational
- ☐ Education/Academic Referral _____ _____
- ☐ Job Training / Work Opportunity _____ _____ _____ _____ _____

Received by Client ☐Gift Card ☐Baby Items ☐Mother Items ☐Food ☐Other_____

Liability Form For Food and Equipment Items

I have been instructed to visually inspect ALL items received from the Life Choice Project. DO NOT use the products if any of these conditions exist: **Expiration date has passed, Safety seal is not in place, Safety button is not depressed and Aluminum cans have swollen tops or bottoms.** I agree that it is my responsibility to act on to correct any or all product recall notices on any product received by me.

I, (Print full name)_____, have received from the Life Choice Project of Louisiana, the following (list ALL perishable and non-perishable items):

I agree to not hold the Life Choice Project liable for any damages that may occur while using the food or equipment items I have received.

Signature of client:_____Date_____

Signature of witness_____Date_____

Life Choice Project: Case Management Form 104

Provider: _____ **Provider #**_____ **Client #**_____ **Date of Visit** _____

Check off any services needed:

Referrals
- ☐ Physician/Clinic Referral Name_____
- ☐ Emergency Rooms'
- ☐ _____
- ☐ WIC ☐ Medicaid
- ☐ Counseling
- ☐ Housing Referral
- ☐ Other (specify):_____
- ☐ Family Services Module # ____ - _____

Support Services
- ☐ Prenatal Care Education _____
- ☐ Maternity
- ☐ Baby Clothing
- ☐ Video
- ☐ Baby Care
- ☐ Other_____
- ☐ Other_____

Education & Occupational
- ☐ Education/Academic Referral _____ _____
- ☐ Job Training / Work Opportunity _____ _____ _____ _____ _____

Received by Client ☐Gift Card ☐Baby Items ☐Mother Items ☐Food ☐Other_____

Liability Form For Food and Equipment Items

I have been instructed to visually inspect ALL items received from the Life Choice Project. DO NOT use the products if any of these conditions exist: **Expiration date has passed, Safety seal is not in place, Safety button is not depressed and Aluminum cans have swollen tops or bottoms.** I agree that it is my responsibility to act on to correct any or all product recall notices on any product received by me.

I, (Print full name)_____, have received from the Life Choice Project of Louisiana, the following (list ALL perishable and non-perishable items):

I agree to not hold the Life Choice Project liable for any damages that may occur while using the food or equipment items I have received.

Signature of client:_____Date_____

Signature of witness_____Date_____

Form 106

Louisiana Life Choice Project

Continuing Follow-Up Program Information

Client's Name:_____ **Age:**_____ **Chart #:**_____

Opening date of case:_____ **Closing date of case:**_____

Phone #:_____ **Counselor:**_____

May we identify ourselves when we call? Yes ☐ or No ☐ **Next visit scheduled for:**_____

Intentions: Keep ☐ Adoption ☐ Undecided ☐ Abortion ☐ **Last Known Decision**_____

Date: _____ **Left Message:** Yes ☐ No ☐ No Answer ☐ **Staff Initial:** _____	**First Care Call – complete 24 hours after visit** How is she feeling? _____ Did she have any questions after her visit?_____ Medical visit confirmed Yes ☐ No ☐ Would she like a home visit? Yes ☐ No ☐ Anything we can do for her?_____
Date: _____ **Left Message:** Yes ☐ No ☐ No Answer ☐ **Staff Initial:** _____	**Second Care Call – complete 24 hours after second visit** How is she feeling?_____ Did she have any questions after her visit?_____ Third visit date & time confirmed? Yes ☐ No ☐ Would she like a home visit? Yes ☐ No ☐ On your third visit you qualify for a complimentary gift such as a car seat, baby clothes, diapers, or other items. Which of these would be of interest to you?_____
Date: _____ **Left Message:** Yes ☐ No ☐ No Answer ☐ **Staff Initial:** _____	**Third Care Call –** Interested in Mommie & Me class? Yes-group ☐ Yes-individual ☐ No ☐ Mommie & Me class scheduled for _____ Interested in New Beginnings childbirth class? Yes ☐ No ☐ Sent Postcard Date_____ Initial_____ Reply Yes ☐ No ☐
Date: _____ **Left Message:** Yes ☐ No ☐ No Answer ☐ Staff Initial: _____	**Delivery Information** Due date_____ Actual delivery date_____ Boy ☐ Girl ☐ Baby's name_____ Baby's weight & length_____ How is she feeling?_____ Does she need any help for the baby?_____

Closing date_____ **Reason**_____ **Initials**_____

Life Choice Project Permission to Contact Chart #_____ Form 105

Will you like us on Facebook? Y N

We would like to keep in touch with you and hear how you are doing. May we contact you? Y N

Do you have caller ID? Y N Do you have call block? Y N May we leave a message? Y N

How would you prefer us to contact you? May we text you? Y N
(Note: we cannot email)

Home# ( )_____-_____

Work# ( )_____-_____

Cell # ( )_____-_____

(If you have call block, we will have to unblock our phone to call you, and our number & name will be displayed on the ID screen. Is this all right? Y N

We want to be helpful to those in our community and better serve their needs. Your comments are important to us. Please take a minute to respond to the following:

What is your Nurse/Client Advocate's name?_____

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
I was treated with professionalism and respect when my appointment was made.					
If applicable: I was given a welcome greeting by the receptionist when I arrived.					
I did not encounter any difficulties with staff members during my visit.					
The information given to me was helpful.					
Most people in the world can be trusted.					
My Nurse/Client Advocate treated me with respect.					
My Nurse/Client Advocate answered my questions in a kind manner.					
I feel that I can trust my Nurse/Client Advocate.					
The staff has been honest with me about the services they provide.					
My questions were answered thoroughly.					
My questions were treated like "silly" questions.					
I felt comfortable talking about my concerns.					
If a friend of mine was in my situation, I would recommend that she come here for help.					

Would you like ongoing counseling? Y N

Will you make a purity pledge to remain abstinent until marriage? Y N

If applicable: The people who visited my home were kind and helpful. Y N

If applicable: The room I sat in while talking with the Nurse/Client Advocate was very comfortable. Y N

Thank you for allowing us to serve you and for helping us to improve the services we provide

Comments:_____

*Client Signature*_____ *Date*_____

Life Choice Project Questionnaire Chart #_____ Form 105-M

Father's Name _____

*Father's Signature*_____ *Date*_____

We want to be helpful to those in our community and better serve their needs. Your comments are important to us. Please take a minute to respond to the following:

What is your Staff/Client Advocate's name?_____

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Was the Fatherhood information helpful?					
My Staff/Client Advocate treated me with respect.					
My Staff/Client Advocate answered my questions in a kind manner.					
The staff has been honest with me about the services they provide.					

What program do you think will benefit you? Check one

____ New Born Care

____ How to deal with crying and colic?

____ What is age appropriate discipline?

What is the likely hood you will participate in the programs?_____

Would you like a mentor to coach you and give you tips on fatherhood? Yes or No

Comments:_____

_____

_____

_____

Thank you for allowing us to serve you and for helping us to improve the services we provide

LIFE CHOICE PROJECT
RETURN VISIT

CLIENT NAME _____ CHART# _____ DATE _____ VISIT # _____

Service desired: (circle one) Pregnancy test Retest Medical Support Other

If Pregnancy Disposition is termination then please complete questions 1-3 sign, date and return to receptionist
If Pregnancy Disposition is carry full term please complete questions 1-8 sign, date and return to receptionist

1. Any changes in your income yes _____ no _____
   Please explain _____
   _____
   _____
2. Any changes in your address yes _____ no _____
   Address _____
   City _____ State _____ Zip _____
3. Any changes in your phone number yes _____ no _____
   Home ( )____-_____ Cell ( )____-_____ Other ( )____-_____
4. Do you need a car seat post delivery? yes _____ no _____
5. Do you need help with groceries? yes _____ no _____
6. Do you need baby formula? yes _____ no _____
7. Do you need diapers? yes _____ no _____
8. Can we send you coupon promotions via mail? yes _____ no _____

_____ _____
SIGNATURE DATE

PLEASE ATTACH COPY OF PROOF OF INCOME TO THIS PAGE.
ALL above mentioned supplies are available while supplies last.

Care Pregnancy Clinic

Helping women have healthy babies.

Confirmation of Test Results

(Give original to patient, copy for patient's chart)

Name and Address of Inquirer:

EBR Health Unit
353 N. 12 th St
B.R., LA 70802
(225) 342-1711

Office of Family Support
2751 Wooddale Blvd.
B.R., LA 70805
(225) 922-3000

Office of Family Support
1919 North Blvd.
B.R., LA 70805
(225) 219-1500

To Whom It May Concern:

This is to advise you that –

Who currently resides at-

had a urine pregnancy test at the Care Pregnancy Clinic on _____. This client's test result was positive. This client has not had a physical examination.

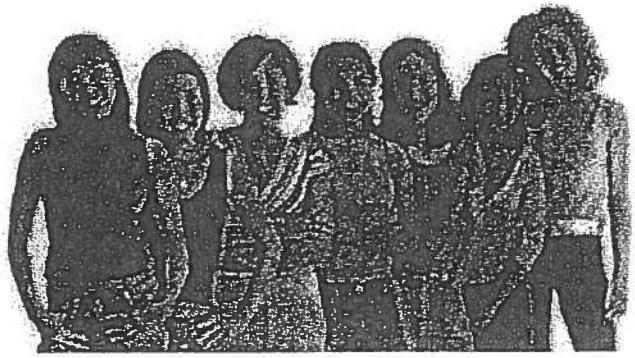
EDD: _____ by LMP

Patient's signature:_____ Date:_____

Nurse:_____ Date:_____

Physician:_____ Date:_____

3813 N. Flannery Rd., Baton Rouge, LA 70814 * (225) 272-3680
Revised 7/1/13 X:\SFW\13-14 Life Choice\Forms\2-7-13 finals\verification form - cpc.doc



Empowering YOU TO CHOOSE

Your Testimony

The Life Choice Project is a non-profit organization funded mainly by compassionate people who give us the finances, to continue to serve our clients at no cost to them.

Could you please write a few lines on how we were able to make a difference in your life?

We have enjoyed the opportunity to serve.

Please come back if you need us again.

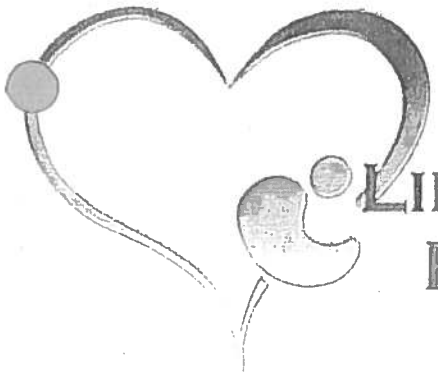
Chart #

Client Name

Rev 1/17/13 Testimony Form

NAME _____

COPY



Life Choice Project

What Can I Expect?
A quick guide to your
Medical Consultation

1. Meet with your Nurse
   A. Medical Consultation
   B. Review of your options
   C. Performs the pregnancy test
   D. Confirm pregnancy and determine Gestational age (how far along you are)
   E. Provides STD testing
2. Provision of your personalized Solutions
   A. Assessment Plan

Tell us about yourself

Have you or anyone living with you recently traveled outside the US in the last 3 months? _____

Where? _____

West Africa? _____

Do you have any of the following (Please check all that apply)

- ☐ High Fever
- ☐ Joint/Muscle aches
- ☐ Diarrhea
- ☐ Unexplainable bruising

Explain _____

Do you shop at "the mall"? _____

Which one _____

What is your favorite clothing store?

_____

Favorite restaurant? _____

Caring to Love Ministries

3813 N. Flannery Road, Baton Rouge, LA 70814
(225) 408-8171. Fax: (225) 273-5931

Verify Citizenship

Name: _____

Address: _____

City, State and Zip: _____

Date: _____

Last 4 digits of Social Security Number: _____

Date of Birth: ___/___/_____ Estimated monthly income $_____

I _____ give CTLM authorization to verify information about my Social Security number, D.O.B., verify citizenship, and/or my place of employment for the proper needed documentation use only. I realize that I will receive free services regardless of my income. This verification is only for the required proof of citizenship.

I am employed by: _____

If employed, do you needs assistance verifying income on line: Yes No

Web address: _____Phone Number: _____

Address _____

Contact Person: _____

Client Signature: _____

CPC Staff or Volunteer Signature: _____

_____ _____

Signature *Title*

Office Use

Job Location _____ Branch _____

Location -Department _____ Building # _____ Client's Phone # _____ Ext_____

Income: _____Verified By: _____ Date: _____ Time: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

1. Authorization, I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. This authorization shall be in force and effect until this authorization expires.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of Patient personal representative

_____

Print name or personal representative and his or her relationship to patient

_____

Date

Life Choice Project

Client Services Assessment Guide Billing Form March 2016 to June 2016

LCP # : _____ SS # : _____ Chart # : _____ EDD : 12/06/2016

ELIGIBILITY INSTRUCTIONS

- Monthly reports are due on the 3rd of each month by 3 pm for eligibility.
- Visit report requires supporting documentation and 3 verification initials for eligibility. 2 verification initials allowed if authorized.
- All assessment guides are to be in chart number order regardless of visit.
- Attach appropriate billing form to visit report, retain top copy for patient records.
- All billing forms must be signed
- Billing error(s) may disqualify reimbursement.

ABV-AD DISPOSITION

___ My Life vs My Baby's Life ___ No Life vs. Quality
___ Regret or Humiliation X Life Minded

FIRST VISIT

Date : 04/07/2016

☐ Father ☐ Family ☒ None

1.0 ☒ Intake Application/Eligibility Process
- ☒ Verify via consent form TANF eligibility (Form 101, 102, 103, 101H

FIRST VISIT - POSITIVE TEST

2.0 ☒ Positive Pregnancy Test
- ☒ Pregnancy Confirmation
- ☒ Pregnancy Consultation

3.0 ☒ Counseling (Client/Partner/Family)
- 45 Length of Visit (# minutes)
- ☒ Non-directive Counseling

4.0 ☒ Health Risk Assessment (Form 203)
- Risk Assessment (Nutrition, Health Education, and Life style)

5.0 ☒ Care Plan Development (203)
- ☒ Prenatal Care Plan (203)
- ☒ Save Haven (203)
- ☒ Follow-up Program Info (Form 106)
- ☒ Exit Interview (Form 105F) EDD date
- ☐ Exit Interview - Male (Form 105M)

FIRST VISIT-NEGATIVE TEST

7.1 ☐ Negative Pregnancy Test
8.1 ☐ Abstinence Education (Form 301N)

SECOND VISIT OR EXTENDED VISIT

Date : 04/07/2016

☐ Father ☐ Family ☒ None

10.1 ☒ Referral Services (Form 104)
- ☒ (WIC, food stamps, other services etc.)

___ ☒ On-Going Care & Monitoring
- ☒ Consent (Form 234)
- ☐ Follow-up Assessment (From 301)

___ ☐ Pregnancy Confirmation 2.1

___ ☒ Re-assess high/risk factors/nutrition
- ☒ Re-assess lifestyle concerns
- ☒ Ed./VocationalPlanFollow-Up(Form 301)
- ☒ Inform Client of complimentary services

___ ☒ Support Services #1 (Form 301)

You ought to know

List counseling curriculum, i e., First 9 Months)

THIRD VISIT

Date : 04/12/2016

☐ Father ☐ Family ☒ None

10.1 ☐ Referral Services (Form 104)

BRCC

(Academic, educational, and occupational))

___ ☒ Pregnancy Confirmation

11.1 ☒ On-going Care & Monitoring
- ☒ Consent(From 234)
- ☒ Follow-up Assessment (Form 302)

☒ Re-assess high/risk factors/nutrition
- ☒ Re-assess lifestyle concerns
- ☒ Schedule Child Birth/Parenting Classes
- ☒ Client of complimentary services

___ ☒ Counseling

___ ☒ Support Services #2 (Form 302)

Preg & Nutrition Age 31

List educational DVD, i.e., nutrition or marriage video)

FAMILY SERVICES (must be in date order)

First Trimester Total wks. Now ___

13.0 ☒ Module 1 - The First Trimester Date : 04/07/2016
- ☒ Pre-Natal
- ☒ Nutrition
- ☒ Developing Baby
- ☐ Father ☐ Family ☒ None

___ ☒ Module 2 - Smoking Date : 04/07/2016
- ☒ Products and Activities
- ☐ Father ☐ Family ☒ None

Second Trimester Total wks. Now ___

13.1 ☒ Module 3 - Baby's World Date : 04/07/2016
- ☐ Babys Secret World
- ☐ SIDS Reduction
- ☐ Father ☐ Family ☒ None

___ ☒ Module 4 - Ready for Baby Date : 04/12/2016
- ☒ Getting Ready for Baby
- ☒ Infant Temperament
- ☐ Father ☐ Family ☒ None

___ ☒ Module 5 - Infant Massage Date : 04/12/2016
- ☒ New Born Care
- ☒ Crying, Colic, Sleeping
- ☐ Father ☐ Family ☒ None

Third Trimester Total wks. Now ___

13.2 ☒ Module 6 - Parent-Child Date : 04/12/2016
- ☒ Self Esteem
- ☒ Communication
- ☐ Father ☐ Family ☒ None

HOME OUTREACH SERVICES

Date : 04/13/2016

☐ Father ☐ Family ☒ None

14 ☒ Home Outreach Services (as applicable- 101-H)
- ☒ Medical Consultation (form 402)
- ☒ Nutrition, Health Education,Lifestyle(103-H)
- ☒ DVD

___ ☒ Module #7 - Emergency First Aid Accidents
- ☒ Car Seat Safety
- ☒ Teaching Love
- ☐ Father ☐ Family ☒ None

___ ☒ Re-Risk Assessment

BIRTH OUTCOMES

Date : ___

☐ Father ☐ Family ☐ None

15 ☐ Confirmation
- ☐ Followup Assessment HV Consent(501&101-H)
- ☐ Social/psychological assessment and Counseling
- ☐ Assessment for Pregnancy Outcome
- ☐ Referral for Post-partum Intervention
- ☐ Educational/Vocational Plan follow-up (203-P)

IN KIND SERVICES

LIFE CHOICE PROJECT

3813 N. Flannery Road, Baton Rouge, LA 70814

PLEASE PRESS FIRMLY TO RECORD BILLING INFORMATION

Form Completed by:

_____

First Name Last Name

_____

Signature

Must be signed by authorized representative for processing
For questions or additional information, please refer to your Executive Director. Rev. 07/1/15

ALL Manual Adjustments Must be Initialed to the Left of the # Service Line ____

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Maternal Life Development

Personal Relationships	↑ Healthier self-esteem ↑ Preservation of long-term relationships ↑ Increase awareness of the value of inter-personal relationships ↑ Increase awareness of resources and assistance available for victims of domestic violence
Abstinence Education	↑ Informed decision-making ↑ Longer intervals between pregnancies ↑ Improved parent-child relationships ↑ Improved maternal health from spacing pregnancies at least 2 years apart ↑ Increased access to prenatal care information and resources ↑ Decreased personal stress related to unplanned pregnancy
Women' Health Mind, Body, & Soul	↑ Increase awareness of women's health concern ↑ Improved self-esteem, mental, physical health ↑ Better stress management and coping skills ↑ Increased understanding of self-care and access to health care
Education/ Job Training	↑ Completion of goals ↑ Improved employability ↑ Improved job stability ↑ Improved financial status ↑ Healthier self-esteem ↑ Decreased need for public assistance
Homemaker role	↑ Increased sense of personal value and self-esteem ↑ Increased desire to excel ↑ Improved access to resources for the family

Life Choice Project

Prenatal Care Education Checklist

Ask the parents *"How do you learn best"* Check all that apply.

- ❑ verbal instructions and talking about it
- ❑ by doing, touching, and feeling
- ❑ through computers
- ❑ visually, through videos and pictures
- ❑ reading about it
- ❑ other? _____

Initial and enter the date and the topic was discussed in the box that corresponds with the mother's learning level.

Education Topics	New Concept	Heard it before, Needs more review	Is learning info Well, review again	Know it well enough to teach someone else
Tobacco, alcohol, and drugs during pregnancy				
Smoking cessation information and referral				
Normal symptoms of pregnancy				
Prenatal Classes				
Breast vs. bottle feeding				
Nutrition/weight gain/WIC				
Fetal growth and development				
Fetal movement/kick counts				
Sex during and after pregnancy				
Signs of labor				
When to call the doctor to go to the hospital				
Stages of labor & delivery				
Postpartum Depression				
Care of the infant				
Attachment and bonding				
Safety				
Sibling rivalry				
Maternal Life Course Development				
Work and exercise				
Abstinence Education, pregnancy spacing				

Parenting Education Checklist

Ask the parents *"How do you learn best"* Check all that apply.

- ❑ verbal instructions and talking about it
- ❑ by doing, touching, and feeling
- ❑ through computers
- ❑ visually, through videos and pictures
- ❑ reading about it
- ❑ other? _____

Initial and enter the date and the topic was discussed in the box that corresponds with the mother's learning level.

Education Topics	New Concept	Heard it before, Needs more review	Is learning info Well, review again	Know it well enough to teach someone else
Tobacco, alcohol, and drugs				
Smoking cessation information and referral				
Sleep position of SIDS				
Postpartum Depression				
Normal infant appearance and behavior				
Well baby check-up schedule and immunization				
Care of the infant				
Breast vs. bottle feeding				
Nutrition/weight gain WIC				
When to call the doctor to go to the hospital				
Anticipatory guidance on child development				
Brain and literacy development				
Crying, colic and Shaken Baby Syndrome				
Attachment and bonding				
Parenting classes and new parental roles				
Safety				
Sibling rivalry				
Maternal Life Course Development				
Work and exercise				

Coordinated Prenatal Care - Support Services

Earn While You Learn

One of the Support Services offered is *"The Earn While You Learn Program"*, an education-based system of earning items expectant mothers may need for their babies. *Mommy and Daddy* earn "money" by keeping a one-hour appointment for a parenting session. Each lesson is taught through a series of videos and worksheets that cover everything from pregnancy to newborn care. During their appointment a video may be shown followed by the review of a worksheet and then a discussion of the lesson. To earn additional "money" parents can do also homework to be discussed during their next appointment. The value of the "money" can range from $3.00 to $5.00 and with just one lesson parents can earn enough to make a "purchase" valued at $25.00 worth of products in the Mommy Store! *"The Earn While You Learn Program"* has over 40 lessons plans which are individually tailored to parents' specific need. Sample Lessons include:

First Trimester

Lesson Objective:

Before their first visit we give our clients an overview of the beginning part of her pregnancy and to help her connect with her baby, even though she can't feel the baby and encourage our young woman to ask questions. Discuss the link between low birth rate early prenatal care, nutrition and pregnancy termination. Go over SAFE Haven information: It's Legal in Louisiana if you or someone you know is not ready to take care of a newborn, Louisiana's Safe Haven Law offers parents a safe, legal option.

Prenatal Care

esson Objective:

To equip our clients with an understanding of what will happen during the first visit, what test will be done, what the results mean and what rights they have. Also, encourage them to ask questions and give the confidence to take ownership of their pregnancy. Let her know that we will be calling her for a home visit. Looking at the adoption choice in a safe, unpressured environment and help her clarify her thoughts and explore her emotions on this choice.

Nutrition

Lesson Objective:

To help our clients bond with the baby inside and to appreciate the complexity and beauty of her developing baby. This will, hopefully, inspire her to eat well and take care of "herself" Let her know that when we will be calling her for a home visit we will bring her groceries to help her with proper nutrition. Q and A concerning the risk of Low birth rate babies, importance of proper nutrition, early prenatal care and pregnancy termination.

Your Developing Baby

Lesson Objective:

To help our clients bond with their baby and to appreciate the complexity and beauty of her developing baby. To help our clients to understand and appreciate their body's response to pregnancy. To help prepare them for the changes they will experience which will reduce anxiety about their pregnancy. This will, hopefully, inspire her to eat well and abstain from alcohol, tobacco and drugs to take care of "herself".

Productions and Activities

Lesson Objective:

Teach our clients the dangers of smoking while pregnant even if she doesn't smoke, she will likely know someone while pregnant and she can share this information. Also, she needs to know about eh dangers of second hand smoke.